CLAIMS DETERMINATION AND HEARING PROCEDURE UNDER THE EMPLOYEES' STATE INSURANCE ACT

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PREFACE

Social insurance is an important aspect of social security; and the subject is growing in significance with the rapid pace of industrialisation and urbanisation in low-income countries. This study of the process of Claims Determination and Hearing Procedure Under the Employees' State Insurance Act, two of its most important aspects, by Prof. Ralf Fuchs of the Indiana University, who was recently in India as a Visiting Professor in the Indian Law Institute, and by Prof. V. Jagannadham of the Indian School of Public Administration, is based upon an examination of the law on the subject and the data made available by the Employees' State Insurance Corporation. The idea of the joint project had its genesis in the discussions between the authors during the ECAFE Seminar on Asian Regional Training Course in Social Security Administration held in Delhi in November 1960. The study was originally published in the Journal of the Indian Law Institute; but, in view of the interest of the subject for a larger public, it was decided to publish it as a separate monograph under the auspices of the Indian Institute of Public Administration. Our thanks are particularly due to the Indian Law Institute and Prof. Fuchs for permission to reprint the article in this form.

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Director

The Indian Institute of Public Administration
New Delhi
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INTRODUCTION

The Employees' State Insurance Act (34 of 1948) is India's initial piece of modern social security legislation. Poor relief in western countries, stemming from medieval times, provided uncertainly against destitution. Workmen's compensation, the forerunner of social security, has since the latter part of the 19th century and since 1923 in India provided a simplified means of indemnity to the victims of industrial accidents and disease. These measures, however, did not satisfy the demand for a political and legal guaranty against "freedom from want," to which the existence of an economic surplus in western countries gave rise, and which has spread to other lands.[1] This demand has found expression in the statement of Article 22 of the United Nations Universal Declaration of Human Rights, adopted in 1948, that "Everyone, as a member of society, has the right to social security," and in that of Article 25 which says:

> "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness,

1. It may be remarked that an economic surplus in India in the time of Ashoka and subsequently under other benevolent rulers resulted in national government measures which had some of the characteristics of a Welfare State.

disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

It has also given rise to the inclusion in the Constitution of India of Article 41, in the Directive Principles of State Policy, which declares that "The State shall, within the limits of its economic capacity and development, make effective provision for securing the right...to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want."

Social security, which originated in Germany under Bismarck and has since spread to other countries, envisages protection against an entire range of causes of personal insecurity in an industrial society; and it extends its protections as a matter of right through safeguarded procedures. Usually the aspect of right to statutory benefits is emphasized by the creation of a fund built up by employer and employee contributions, from which claims are paid; but even when the necessary resources come from ordinary taxation, the procedure by which the claims are entertained, including a hearing on request, strengthens the legal right to authorized benefits, which the statutes establish.

The Employees' State Insurance Act establishes the Employees' State Insurance Corporation in the Government of India to assume charge of the benefit fund which the Act creates, to administer in conjunction with the States the medical services for which the Act provides, and to pay cash benefits from the fund. It also accords to claimants who are dissatisfied with the Corporation's actions the right to adjudication of their claims by the State Employees' Insurance Courts for which provision is made, with a further right of appeal to the State High Courts on substantial questions of law.

The Act follows in the manner deemed appropriate to India, standards and proposals which have been formulated by experts in other countries and by international bodies.[2] Socia lsecurity legislation and administration

2. *Handbook of Social Insurance Administration*, Int'l. Labour Office (D. 6(1)—1959).

throughout the world have benefited from the common interest which has lain behind their development, from the recency of their origin which has permitted a rational design to be imparted to them, and from the continuous international exchange of information, experience, and views which has taken place.

The inquiry of the authors has been conducted on the basis of published material, interviews,[3] and records supplied by the Corporation, including the unpublished decisions of the Employees' Insurance Courts in selected States during 1960. The published material includes the governing statute and regulations and the printed instructions which are issued for the guidance of administrative personnel. We have also been accorded access to past reports of special studies of certain phases of the administration of the Employees' State Insurance Act, which have been made at the request of the Corporation, together with certain detailed recommendations for possible amendments to the Act, which the Corporation still has under consideration.

GENERAL ASPECTS OF ADMINISTRATION

The Employees' State Insurance Act provides five types of benefits, namely, (1) medical benefits, (2) sickness cash benefits, (3) disablement benefits, (4) dependents' benefits, and (5) maternity benefits. The disablement and dependents' benefits take the place, in establishments to which the Act extends, of the provision made for similar benefits under the Workmen's Compensation Act (8 of 1923). The Act provides that its several provisions shall come generally into force in such particular areas as the Central Government may by notification appoint, but

3. The authors have had the benefit of generous assistance from the administration of the Employees' State Insurance Corporation. The Director-General, Shri V.N. Rajan, the Officer on Special Duty, Shri S.K. Wadhawan, the Assistant Insurance Commissioner, Shri V.A. Mutatkar, the Director of the Delhi Region, Shri J.D. Gakhar, and the Director of the Delhi local Office in Industrial area c/45, Kirti Nagar, Shri V. Singh, have given generously of their time and knowledge and have made pertinent records and documents available to us. For all of these aids, which alone have made this study possible, we are deeply grateful.

that different dates may be appointed for different provisions;[4] that its provisions shall, within an area, apply in the first instance to all factories, including factories belonging to the government, other than seasonal factories;[5] and that the appropriate government in consultation with the Corporation and, where the appropriate government is a State Government, with the approval of the Central Government, may apply the provisions to any other establishment or class of establishments.[6] Factories and classes of factories may be exempted by the appropriate governments for one-year periods, subject to renewal; and government factories where the employees enjoy substantially similar or superior benefits may be exempted altogether.[7] "Factory" means any premises on which 20 or more persons are working or were working on any day of the preceding 12 months, and in any part of which a manufacturing process is being carried on with aid of power or is ordinarily so carried on, except mines subject to the operation of the Indian Mines Act or a railway running shed.[8] Certain general provisions of the Act were, after its adoption, promptly applied throughout India.[9] The benefit provisions were originally applied in 1952 to the State of Delhi and the Kanpur area of Uttar Pradesh, and have since been extended by successive stages to other industrial areas.[10]

The principal administrative units of the Corporation, aside from the membership of the Corporation itself, which is representative of government, industry, and labour,[11] include a Standing Committee which is responsible for administering the affairs of the Corporation,[12] and an Advisory Medical Benefit Council.[13] The actual contact

4. S. 1(3).
5. S. 1(4).
6. *Ibid.*
7. S. 87.
8. S. 2(12).
9. Annexure to the Act as published (1959) by the Manager of Publications, Delhi, p.48.
10. *Id.*, pp. 48-58.
11. Employees' State Insurance Act, s. 4.
12. *Id.*, ss. 8, 18.
13. *Id.*, s. 10.

with beneficiaries takes place, naturally, through local offices of the Corporation which have been established in the various industrial areas.[14] These offices are grouped in regional units,[15] each of which is headed by a director and is subject to the over-all direction of the Insurance Commissioner and supervision of the Director-General at national headquarters in Delhi. Medical referees, to whom medical problems are referred, are available in the regions.[16] Dispensaries or hospitals through which medical services are rendered to beneficiaries have been established in many areas. The Employees' Insurance Courts have been established in the various States.[17] The Corporation also has power to appoint regional boards, local committees, and regional and local medical benefit councils, which shall exercise such powers and functions as may be delegated to them by regulation.[18] The Corporation and the Central and State governments have general power to provide by regulation for the administration of the Act.[19]

There are 15 regional offices, one in each of the States and the Union territory of Delhi, together with 281 local and branch offices distributed among the regions.[20]

A typical local office of the Employees' State Insurance Corporation possesses a structure and follows procedures geared to processing claims. A receptionist may be present to assist claimants in filling out forms. Claims clerks receive claims for medical, sickness, and maternity benefits, accompanied by certificates; render assistance if there is no receptionist; enter on to "shuttle cards" the pertinent information from the employee's "contribution cards" previously received from the employers, which the clerk has available in his file; and calculate and enter the proper

14. *Infra*, text at note 20.
15. *Ibid.*
16. Regulation 105 of the Employees' State Insurance (General) Regulations provides for medical re-examinations when requested by Local Office managers, and the medical Referees have been appointed for this purpose.
17. *Infra*, text at note 20.
18. Employees' State Insurance Act, s. 25.
19. Ss. 95-97.
20. E.S.I. Corp. 1959-60 Annual Report, pp. 17-18 and App. xiv.

amounts of benefits to be paid. A head clerk then verifies the work of the claims clerks. The Local Office manager next receives the papers for his approval of the payments entered, personally checking not less than ten per cent of the individual files for accuracy. Afterwards a cashier pays in cash the approved claims which come to him. The claimants usually wait while the foregoing operations are completed. Claims which require further verification are retained by the office and the claimants are notified when to return, unless they choose the option of payment by money order—an option which is also available for continuing payments which do not require the submission of supplementary claims. Claims based on industrial accident or disease are usually received by an upper division clerk who also assists the manager in establishment matters, and are retained in the local office for verification and subsequent action. A general business clerk, record sorter, and peons complete the Local Office personnel. The manager, of course, may refer readily to the regional office and is expected to call on the medical referee to ascertain the facts with regard to doubtful claims.

The basic method of determining benefits involves, as it would in a private organization of similar character, the ascertainment of facts, their entry of record, and decision upon the record. The resort to further proceedings, involving a hearing if need be and if demanded, comes later. For all types of benefits except dependents' benefits, the facts involved are chiefly of two kinds; the physical condition of the claimant, ascertainable by medical examination, and the past employment and contribution record of the claimant. In cases of claims for long-term disablement, physical condition involves not only the existence of injury or disease but also the degree of resulting disability. If dependents' benefits are claimed, the fact of death and the required relationship of the beneficiaries to the insured worker must, of course, be established; and in any case of benefits to the worker himself during illness or short-term disablement, his absence from employment during the period for which payments are claimed must also be established.

In the great bulk of cases the facts are ascertained routinely by medical examination, examination of contribution records, inspection of forms, and interviews to secure completeness of data and to obtain verification of personal identity. In cases of suspected fraud or malingering an inquiry by a Medical Referee may be necessary; in respect to all claims based on industrial accident or disease the claims are checked against employers' records; and in respect to any claim the local office manager may, if he thinks necessary, call for evidence from the claimant by way of supplement to that which has been routinely furnished.[21]

Although the prescribed procedures do not make provision for administrative review of an initial determination, Local Office managers, regional directors, and even the national headquarters of the Employees' State Insurance Corporation in fact hold themselves open to receive and consider both oral and written complaints from dissatisfied claimants, such as are actually made with some frequency even though, relative to the total flow of claims, they are few in number. The availability of such an informal, supplementary method of consideration doubtless contributes to the satisfaction of the Corporation's clientele with the administration of the Act.

CLAIMS DETERMINATION UNDER THE EMPLOYEES' STATE INSURANCE ACT

Submission of Claims

Social security provides benefits after prescribed procedures have been followed. Beneficiaries are required to put in claims for all forms of benefits, with appropriate certificates of evidence from recognised or competent authorities. The claim is therefore the primary document necessary for receiving benefit.

The Employees' State Insurance Act and the regulations under the Act have detailed provisions regarding the various matters connected with claim forms, filling of forms, consideration and disposal of forms.

21. Employees' State Insurance (General) Regulations, s. 48.

Section 80 of the E.S.I. Act says that payment of benefit cannot be allowed by an Employees' Insurance Court unless a claim is made for such benefit in accordance with the regulations made under the Act, within twelve months, after the claim became due, provided that in certain cases delays may be excused and payment may be ordered by the court where it is satisfied that there was reasonable excuse for not making the claim in due time. Responding to this provision, the Employees' State Insurance (General) Regulations 44 to 95 deal with claims for benefits and the certificates that support the claims.

Section 46 of the Act provides for entitlement to the five benefits mentioned above. Sections 47, 49, 50, 51, 52, 53 and 56 provide for the conditions and rates of benefits for the persons entitled to claim benefits. These sections make it clear that the payment, at least of certain benefits, bears relationship to the contributions prescribed under the Act.[22]

The claim must be in writing and on the appropriate form, but the requirement as to form may be waived provided the claim is made in writing.[23] The claim must be submitted to the Local Office where the insured person is registered. The claim forms for sickness benefits are printed on the sickness certificates.

The fifth benefit, namely, medical benefit, is a benefit in kind and an insured person or his family becomes eligible to it as per conditions laid down in sections 56 and 57 of the Act and regulations 103 and 103A.[24]

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22. As soon as a person joins a factory covered by the E.S.I. Act, he will be registered as an insured employee and contributions will be deducted from his wages. In order to facilitate the work of the employer and of the Regional Office in the matter of collection of contributions, the insured persons in all the factories covered by the Act are divided into 3 sets, A, B and C. For each set of persons there is a different contribution and corresponding benefit period. There is normally an interval of twelve to fourteen weeks, called staggering period, between the end of a contribution period and the beginning of the corresponding benefit period.

23. Reg. 44.

24. The claims for the respective benefits fall due on the days prescribed in regulation 45: (1) For sickness or temporary disablement on the date of the issue of the medical certificate after due concession for the waiting period prescribed in the statute; (2) for maternity (*a*) on the date of issue of the certificate of expected confinement (*b*) on the day six weeks preceding

The claims forms are available in the Local Office free of charge.[25] The Local Office also supplies assistance to fill the forms for insured persons who cannot fill the forms themselves.[26] Notwithstanding such assistance, if a beneficiary submits a claim in a form other than the appropriate form the Local Office may treat it as valid but require the claimant to complete the appropriate form also.[27] Similarly, a wrongful mixture of claims, or claiming a benefit other than the one which is due, may be corrected by the Local Office, and any such claim may be treated as a claim for the benefit which is payable.[28] Provision also exists under regulation 49 for rectifying a defective claim. A claim may be defective by virtue of absence of due signature or due certification. In such cases, the Local Office may, in its discretion, refer the claim to the claimant and the signature or certificate may be supplied within a period of three months from the date of reference. Such rectification validates the claim from the date of its first submission.

The objects of the emphasis on prompt submission of certificates, which is required, are to discourage malingering and make the benefits available when they are needed. Where the medical certificates are promptly submitted, the Local Office can, in doubtful cases, arrange to get the insured person examined by the Medical Referee before the end of the incapacity period. Such examinations help to distinguish bona fide cases from the others.

The Local Office manager has power, under regulation

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the expected date of confinement (whichever is later) (*c*) in the absence of either of the foregoing, on the date of confinement; (3) for permanent disablement on the date on which an insured person is declared as permanently disabled; (4) for dependents (*a*) on the date of the death of the insured person in respect of whose death the claim arises (*b*) where disablement benefit was payable for that date, on the date following the date of death, or (*c*) the date from which a beneficiary becomes entitled to claim. According to s. 56, medical benefit is available during any week for which contributions are payable or in which the claimant is qualified to claim sickness benefit or maternity benefit or such disablement benefit as does not disentitle him for medical benefit under reg. 103. Section 57 prescribes the scale of benefit. Reg. 103A prescribes conditions for medical benefit after contribution ceases to be payable.

25. Reg. 46.
26. *Ibid.* 44.
27. *Ibid.* 47.
28. *Ibid.* 50.

64, to relax the requirement of submission of certificates. This is normally not allowed under the following circumstances:[29]

(1) ignorance of the requirements as to submission of certificates (except during the first two years of implementation of the scheme in any area).

(2) forgetfulness.

(3) agents' delay: where an insured person entrusted the task of submission of certificates to some other person who delayed submission. (This may be condoned if the insured person suffers from an incapacity to attend to it personally and there is no one else at home who can submit the certificate.)

(4) employer's delay where the certificate is submitted through the employer. (This too can be condoned provided the employer confirms the correctness of the statement of the insured person.)

(5) misplacement of certificate.

(6) more than three months delay (may be condoned in special circumstances).

Before deciding for or against relaxation the Local Office manager must obtain a written statement of the reasons for delay from the insured person.

Since 1955, however, the Director-General has been empowered by a resolution of the Standing Committee to authorise payment of cash benefit on a claim submitted more than 3 years from the date on which it became due provided he is satisfied that the amount involved is substantial and/or the reasons for late submission are adequate.[30]

Evidence in Support of Claim

The claim for sickness benefit begins its course with an initial form filled by the claimant along with the first medical certificate issued free of charge immediately after

29. E.S.I.C. Instructions on Medical Certificate, March 1960, p. 17.
30. E.S.I.C. Annual Report, 1955-56, p. 20.

examination by the Medical Officer/Practitioner.[31] The first certificate will be followed by an intermediate certificate where sickness lasts for more than three days and by a special intermediate certificate usually issued by a Medical Referee, where sickness lasts for more than twenty-eight days.[32] A final fitness certificate must be obtained before resumption of work.[33] In short spells of sickness the first medical and the final fitness certificates may be combined at the discretion of the medical person attending upon the insured patient.[34]

For extended sickness benefit, payable for certain serious illnesses, in addition to the above certificates, the Medical Officer/Practitioner should get the patient examined by the specialist in the diagnostic centre in the T.B. Hospital and for leprosy, mental and malignant diseases by specialist appointed by State governments and issue the next intermediate certificate with the diagnosis underlined in red ink and a report to the Local Office. The Local Office then submits it for scrutiny and comments by the Medical Referee.[35]

For maternity benefit, the evidence must include (1) notice of pregnancy, (2) certificate of pregnancy (not earlier than seven days from such notice), (3) certificate of expected confinement (not earlier than fifty days from the expected date of confinement) or confinement (within thirty days of the date on which confinement takes place).[36] In the case of a claim for maternity benefit after confinement, the certificate of confinement alone is enough.[37] These certificates are to be issued by the Insurance Medical Officer to whom the patient is attached, or by the one who has attended prenatal care or confinement; or by a clinic, dispensary or hospital to which she is allotted.[38]

31. Regs. 53, 54, 56 and 57.
32. Reg. 59.
33. Reg. 60.
34. Proviso 2 to reg. 57.
35. E.S.I.C. instructions on Sickness and Extended Sickness Benefit Procedure, March, 1960, p. 31-36.
36. Regs. 87, 88.
37. Reg. 89.
38. Reg. 94.

Certificate by a registered mid-wife countersigned by the Insurance Medical Officer also constitutes valid evidence.[39] Even though the woman has obtained treatment or attendance from any other person or hospital or institution, the Insurance Medical Officer has an obligation to issue any of the above certificates to insured women allotted to him or to the clinic, dispensary or hospital of which he is in charge.[40]

In the case of disablement benefit the evidence in support of a claim may be rather complex. There must be a notice of accident by the employee or some other person acting on his behalf to the employer or his nominee or to a responsible person such as Foreman.[41] The notice should contain all the essential particulars as to name, insurance number, and occupation, of the injured person or any one else reporting on his behalf and two on-the-spot witnesses, date, time, place, cause and nature of injury, etc.[42] The entry of these particulars in an Accident Book which has to be maintained under the regulations[43] constitutes notice of accident. After the notice by the employee, the employer[44] should send a report to the nearest Local Office and to the nearest Insurance Medical Officer immediately in the case of serious injuries (*i.e.*, if it is likely to disable the person for 48 hours or more) or in any case within 24 hours, after the receipt of notice. All serious injuries and particularly fatal accidents at the place of employment should be reported to the Insurance Medical Officer and Local Office through a special messenger or otherwise as speedily as may be practicable under the circumstances.[45]

Any question as to whether disablement arising out of employment injury should be treated as permanent disablement must be referred[46] to the appropriate Medical Board constituted under regulation 75 by the Regional Office at the request of the disabled person or the employer or

39. *Ibid.*
40. Reg. 95.
41. Reg. 65.
42. *Ibid.*
43. Regs. 65, 66.
44. Reg. 68.
45. *Ibid.*
46. Reg. 72.

any recognised employees' union or by the Corporation or on the recommendation of an Insurance Medical Officer. The Medical Board submits its report[47] to the Regional Office as to whether the disablement should be treated as temporary and if so, the next date of reference to the Medical Board; or whether the disablement can be declared to be of a permanent nature, and if so, provisional or final assessment of the extent of loss of earning capacity; and in case of provisional assessment, the period for which such assessment holds good. Assessment as to injuries outside of schedule of the Workmen's Compensation Act should be treated as provisional and referred by the Regional Office to the Medical Board for revision at the end of every twelve months.[48]

The recommendation of the Medical Board and the decision of the Regional Office thereupon and the benefit, if any, to which the disabled person is entitled will be communicated to him in writing.

An insured person who has been declared to be permanently disabled by a Medical Board or an Appeal Tribunal has to submit a claim to the appropriate Local Office, by post or otherwise, for payment of permanent disablement benefit for one or more complete calendar months, except in the case of a first payment which may be for less than a month.[49] Thus the evidence in support of a claim for disablement benefit, especially for permanent disablement, is characterized by a complex set of processes.

The evidence for claiming dependents' benefit requires a certificate of death and proof of dependency. A claim for dependents' benefit arises only on the death of an insured person as a result of an employment injury. The information about death must be sent to the Local Office and the nearest E.S.I. dispensary, hospital or clinic.[50] A death certificate should be obtained from the Insurance Medical Officer and if he cannot be reached within 12 hours of the time of

47. Reg. 73.
48. *Ibid.*
49. Reg. 76-A.
50. Reg. 77.

report to him, the body may be disposed of after obtaining a certificate from such a medical officer or practitioner as may be available, who attended the deceased person before death or after for post-mortem. The certificate[51] must state whether death is due to an employment injury.[52] Two other necessary documents are proof of age and proof of the claimant's eligibility for the benefit.[53] The Regional Office may not insist upon submission of documentary proof provided it is satisfied about the bona fides of the applicant or about the truth of the facts relating to any of the above matters.[54] The Regional Office must serve notices on those whom in the course of its enquiries it comes to know as likely dependants;[55] inform them about the law and procedure for claiming dependents' benefit and intimate to them to apply for the benefits within a period of thirty days from the date of such intimation.[56] After the thirty day period, the Regional Office intimates in writing the decision in regard to the claim of each to the dependant concerned or his legal representative or guardian.[57] Each dependant whose claim for benefit has been admitted has to submit to the appropriate Local Office a claim for payment of benefit for a period of one or more complete calendar months except in the case of a first or final payment which may be less than a calendar month.[58]

Processing and Honouring of Claims

The claim form along with supporting evidence may be presented to the Local Office in person or through an agent or messenger or through post or by depositing it in the box provided for the purpose at the dispensary or Local Office to which the claimant is attached. The documents

51. Regs. 78, 79.
52. Reg. 80.
53. *Ibid.* class 2 mentions the documents which may be accepted as proof of age: extract of birth certificate original horoscope prepared soon after birth; certified extracts from baptismal register; certified extract from school record; other evidence acceptable to the appropriate Regional Dffice.
54. *Ibid.*
55. Reg. 81.
56. *Ibid.*
57. Reg. 82.
58. Reg. 83-A.

deposited in the box are collected daily at a fixed time. If, on examination of the claim documents, it is found that some essential particulars such as insurance number or signature or thumb impression of the claimant are missing, the Local Office should get them duly rectified as early as possible. After verifying the correctness and validity of the documents, the Local Office carries over the necessary particulars to a shuttle card. The claims clerk at the Local Office enters in the diary all the documents received. He also checks the identity of the claimant if he personally filed the documents on the basis of the identity card.

Sickness Benefit

In regard to sickness benefit the claims clerk checks the relevant particulars for determining the claim such as the total number of days of certified incapacity since the date of the preceding certificate on the basis of which the payment was made; whether 56 days benefit has not already been drawn during the preceding 365 days; whether certification is regular; whether certificates have been submitted in time; whether claim is not one for which incapacity reference is necessary/or pending and whether any more information is needed to determine the claim.[59] If the claims clerk finds that benefit is payable for all or some of the days covered by the certificate he makes the necessary entries in the register and initials it.[60] He prepares the benefit payment docket and benefit payment slip. If benefit is not payable he prepares a Regret Slip. The benefit file would then be passed on to the checker. Where the claim is presented by the agent[61] or messenger of a claimant, the claims clerk checks the letter of authority and a receipt payable to the insured person. He also examines the identity card of the insured person and his signature on the

59. E.S.I.C. instructions on Sickness and Extended Sickness Benefit Procedure, March, 1960, p. 11.

60. *Ibid.*, p. 12. The references to subsequent procedures outlined in the text are from E.S.I.C. instructions on Temporary Disablement Procedure. References in this and Permanent Disablement and Dependants' Benefit Procedures are given in paras. instead of pages because these instructions were available to us only in proof form.

61. Instructions on T.D.B. Procedure, para. 72.

letter of authority. Verification is also made of the identity card of the agent or messenger. If identification of the agent is not possible, the payment cannot be made to him and he would be advised to request the insured person to attend personally or send his consent to make the payment by money order.[62]

The checker examines the certificates, claim form, the title to benefit, and calculates the amount of benefit where due.[63] He checks the entries in the benefit file, the benefit payment docket, the benefit payment slip or the regret slip.

After the checker, the manager[64] goes through all the entries in at least 10% of the cases and if he agrees with the recommendations of the claims clerk and the checker he signs the benefit payment slip or regret slip as the case may be. In case he differs[65] from their recommendations, the entries in the benefit payment file would be revised accordingly. In order to ensure the correctness of the claims, the clerk in charge or the head clerk should check 5% claims passed by the checker.[66] The head clerk or the clerk in charge can pass claims when the manager goes on casual leave subject to latter's *ex post facto* sanction.[67] In all admitted claims, the cashier makes the payment after satisfying himself about the identity of the person receiving payment and getting a proper receipt for the payment made.[68]

In the case of a claim for sickness benefit spread over a prolonged period, an incapacity reference would be made to a Medical Referee. The types of cases required to be so referred are:[69]

(1) cases of sickness of 4 weeks or of longer duration except T.B., cancer, etc.,

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62. For Payment by M.O. *Vide*, *Ibid.*, paras. 74-75.
63. *Ibid.*, p. 77.
64. *Ibid.*, paras. 78-80.
65. *Ibid.*, para. 81.
66. *Ibid.*, para. 82-A.
67. *Ibid.*, para. 83.
68. *Ibid.*, paras. 88-91.
69. E.S.I.C. instructions on Sickness and Extended Sickness Benefit Procedure, March, 1960, p. 14.

(2) cases in which there are frequent changes in the disease recorded by the Insurance Medical Officer on different certificates for the same spell of sickness,

(3) cases which the manager of the Local Office considers it necessary to refer, and

(4) cases in which the Insurance Medical Officer himself requests to have second medical opinion.

Payments of amount due under all correctly completed claims may be made to the claimant personally or to his authorised agent or sent by post. Normally the claimant comes to the Local Office to enquire about or receive payment. If he does not come within fifteen days of the information so sent, the benefit file would be restored to the regular cabinet.[70]

Extended Sickness Benefit

In the case of extended sickness benefit, the claim for it would be entered in the diary examined and passed in the same way as ordinary claims for sickness benefit but would be stamped in red ink as 'Tuberculosis', 'Leprosy', 'Mental' or 'Malignant Disease' Benefit. All the entries pertaining to extended cash benefit on the benefit file are required to be in red ink. The shuttle card initiated by the claims clerk would be examined by the checker and put up for the signature of the manager of the Local Office[71] who would send it to the Regional Office which transmits information about the case to the Administrative Medical Officer and the dispensary and the information about the duration of benefit on a shuttle card to the Local Office. In case a person is eligible at the same time to sickness and extended sickness benefit, the latter can be sanctioned even intermittently for 309 days during a period of 3 years of extended benefit excluding the days on which the insured person is entitled to sickness benefit at the full rate.[72]

70. Instructions on T.D.B. Procedure, paras, 90, 101, 102.
71. E.S.I.C. instructions on S. & Ext. S.B. Procedure, p. 35.
72. E.S.I.C. Instruction No. 61/60 Dt. 6 Oct. 1960. Memorandum on Extended Benefit to Insured Persons, p. 1.

The procedure for payment of extended sickness benefit in case of leprosy, mental and malignant disease is the same as for tuberculosis provided the eligibility condition is satisfied independently for each disease and provided further that the extended period in respect of any two diseases does not run concurrently.[73] List of common morbid conditions included under Cause Groups—Malignant Disease, Leprosy and Psychosis—are given in an appendix to the pamphlet on Instructions on Sickness and Extended Sickness Benefit Procedure. The matter should be referred for confirmation by Insurance Medical Officer/Practitioner to a specialist appointed by the State Government.[74] Where no specialist has been appointed the case would be referred to the Medical Referee who would prepare a report in consultation with the Insurance Medical Officer/Practitioner. If necessary, the insured person may be examined by the Medical Referee also. Afterwards, the case would be sent to the headquarters for decision. The Director-General provides the specialist's advice in respect of the confirmation of diagnosis till such time as State Government appoint specialist for the purpose.[75]

Maternity Benefit

The Local Office enters in the diary the notice and certificate of pregnancy.[76] It has to verify the particulars as to insurance number, address and signature or thumb impression of the insured woman and if there are any defects, it must get them rectified. Where the certificate of pregnancy reaches earlier than notice the Regional Office on reference to it by the Local Office may allow it to be treated as notice also.[77] Notice delayed beyond two months or certificates of expected confinement issued prematurely are liable to be rejected and the claimant may be required

73. *Ibid.* Also *Vide;* E.S.I.C. instructions on S. & Ext. S.B. Procedure pp. 46-47.
74. *Ibid.*, p. 47.
75. *Ibid.*
76. Instructions on Procedures relating to Maternity Benefit March, 1960, pp. 4-5 (This document will be referred to hereafter as I.P. M.B.).
77. *Ibid.*, p. 2.

to resubmit them.[78] The Local Office verifies the particulars as to age, name and insurance number of the person, the stamp of the dispensary, the date after words "on or about", the date of the certificate which should not be more than 50 days before the date of expected confinement.[79] When the claim form and certificates are in order, the claims clerk ascertains the twelve week period and the rate of benefit.[80] If within the twelve week period the claimant resumes work, benefit comes to a stop for it cannot be claimed while earning wages. If she gives up gainful employment during the twelve week period, she can apply again for benefit for non-wage earning days.[81] There has to be a check of 10% of the cases for ascertaining from the employer about the abstention from work.[82] Where maternity benefit is not admissible, she can claim sickness benefit provided she is eligible for it[83] and if she is not entitled to either benefit, the Local Office despatches a regret slip. Where death of the insured woman prevents her full enjoyment of maternity benefit before, during or after confinement, the benefit accruing up to the date of death is payable to the nominees of the deceased person.[84]

Temporary Disablement Benefit

The claim for temporary disablement benefit is processed in much the same way as sickness benefit except for consideration to be given to the accident report. The manager of the local offices decides whether further investigation is necessary but shall conduct such investigation in all cases of occupational diseases, fatal accidents, or accidents outside factory premises or serious cases.[85] Assisted by the Insurance Medical Officer, the manager also decides whether accident has resulted in employment injury.[86] The

78. Reg. 88. Also *Vide* Instruction on Maternity Benefit Laws p. 7 and I.P.M.B., pp. 2-4.
79. I.P.M.B., pp. 3-4.
80. *Ibid.*, pp. 10-11.
81. *Ibid.*, pp. 15-16.
82. *Ibid.*, p. 17.
83. *Ibid.*, p. 16.
84. *Ibid.*, pp. 16-17.
85. E.S.I.C. instruction on Temporary Disablement Benefit Procedure (referred to hereafter as I.T.D.B.P.).
86. *Ibid.*, paras. 32-34.

investigating officials also collect information as to previous employment, wages and contribution record of the injured person.[87] If contributions have been paid at all within the preceding 52 weeks, the benefit is payable according to daily wage rate though benefit cannot be withheld on account of non-payment of contributions; but if there are violent fluctuations in contributions, the facts about fixing stamps of correct denomination may be ascertained.[88] Where no contributions at all have been paid, benefit is determined with reference to the monthly wage under the Workmen's Compensation Act.[89] The Local Office manager refers to the Regional Office for decision all cases where there are substantial discrepancies in the reports submitted by different authorities, where there are doubts as to the accident resulting in employment injury.[90] Where the Regional Director decides to refer the matter to Headquarters, he should send all relevant data of the case.[91] Otherwise he communicates his decision to the Local Office. The Local Office also considers whether the injury is compensable because if accident does not lead to actual stoppage of work for more than three days the claimant can get only sickness benefit but if the disablement exceeds three days, and lasts for more than twenty eight days, benefit is allowable for the three days also[92] unlike in sickness benefit where there is, by contrast, an absolute denial of benefit during the two days waiting period. The Local Office manager should also periodically review the cases by making an incapacity reference to the Medical Referees, especially cases of benefit paid beyond 28 days, to examine whether the person is not fit to resume work.[93] Second and subsequent incapacity references are made at regular intervals of fourteen days but also at shorter intervals in cases where the spells of sickness are frequent and are of short duration, where

87. *Ibid.*, paras. 17-31.
88. *Ibid.*, para. 19.
89. *Ibid.*, para. 24.
90. *Ibid.*, para. 34.
91. *Ibid.*, para. 35.
92. *Ibid.*, para. 51, Also Vide, s. 4 of the Workmen's Compensation Act, 1923.
93. *Ibid.*, para. 106.

the diagnosis is vague or where malingering is possible.[94] All cases of lax certification should be brought to the notice of the Regional Office which takes up the matter with the Administrative Medical Officer for further action.[95] Temporary disablement cases in which benefit is paid for more than six months have to be referred to the Medical Board and if necessary to the headquarters by the Regional Office on the initiative of the Medical Referee.[96] Sample check is made of 5% of the cases to ascertain from the employer whether the beneficiary has actually stopped from work; if the insured person is found to be engaged in a manner inconsistent with the conditions of benefit, further proceedings would be taken against him.[97]

Permanent Disablement

A claim for permanent disablement arises only when an insured person sustains an "employment injury" which affects his earning capacity permanently. The processing of a claim under this head starts with ascertaining the view of the Medical Board which is the competent body to decide about the nature and degree of permanent disablement.[98] On the suggestion or initiative of Local Office which keeps a continuous watch over the progress of the disablement case or at the instance of the employer or a recognised employees' union and in consultation with Medical Referee the Regional Office alone can refer the matter to the Board when temporary disablement benefit comes to an end or when doubt exists as to whether temporary disablement is likely to result in permanent disablement.[99] If the insured person insists in writing upon reference to the Medical Board the Regional Office must refer to the Board notwithstanding the negative opinion of itself or of the Medical Referee.[1] The Board examines the insured person and communicates

94. *Ibid.*, para. 107.
95. *Ibid.*, para. 114.
96. *Ibid.*
97. *Ibid.*, para. 115.
98. E.S.I.C. Instruction on Permanent disablement Benefit Procedure (referred to hereafter as I.P.D.B.P.), para. 2.
99. *Ibid.*
1. *Ibid.*, paras. 7-8.

its decision to the Regional Office which later on decides whether permanent disablement has resulted, if so, the percentage of loss of earning capacity; whether assessment of loss is provisional or final, if the former, for how long; the date of discontinuance and the permissibility of lump sum payment in the case of scheduled injuries. The Regional Office should normally agree with the recommendations of the Medical Board;[2] if not, all substantive differences have to be determined through reference by the Corporation to the Appeal Tribunal.[3] The insured person also may prefer an appeal in the case of a negative decision by the Regional Office.[4] Where the decision is affirmative, commutation is permitted in cases involving small periodical amounts under Reg. 76B.[5] Claims for commutation received after six months of date of benefit need a fresh certification of average expectation of life by additional medical examination the expenses for which would be borne by the Regional Office.[6] Claims for commutation should also be pre-audited so that later the question of over-payment may not arise.[7] The monthly rate would be calculated and the beneficiary would be informed in the third week of every month requesting him to claim the benefit for that month.[8] Every claimant should submit a duly certified six-monthly declaration form with the claims for the months of June and December.[9] Besides, the Local Office manager may call the beneficiaries, not more than once in six months, for an interview at the office to satisfy himself about the proper receipt of benefits by the party.[10] The modifying conditions such as waiting or exhaustion period do not affect the permanent disablement benefit and a single clerk handles all matters pertaining to this benefit.[11]

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2. *Ibid.*, para. 8.
3. *Ibid.*, para. 19-A.
4. *Ibid.*, paras. 19-A and B.
5. *Ibid.*, para. 21.
6. *Ibid.*, para. 21-A. Commutation is permitted where the P.D.B. is less than annas two per day.
7. *Ibid.*, sub-para. 5.
8. *Ibid.*, sub-para. 14.
9. *Ibid.*, para. 33-A, sub-para. 5.
10. *Ibid.*, sub-para. 7.
11. *Ibid.*

Dependents' Benefit

This benefit arises on the death of an insured person due to an employment injury either inside or outside the factory.[12] The manager of the Local Office should as soon as he comes to know of the death of the insured person visit the spot, acquaint himself with the facts of death and submit a report to the Regional Office.[13] The Local Office helps each individual dependent to fill the forms separately or jointly.[14] Dependents other than widow and children should get their claims determined directly by the Employees' Insurance Courts.[15] The Local Office assisted by Medical Referee checks the fact of death due to employment injury, status of dependents as claimants and compliance with all the formalities connected with the claims and then despatches papers to the Regional Office.[16] The Regional Office verifies the statements and examines whether death is due to wilful disobedience of safety rules or whether the deceased was under the influence of drink or drug though these factors do not disentitle the dependents from their benefits.[17] After verification of the respective claims of dependents, each will be informed of his or her eligibility.[18] In the case of claimants other than widow or children, the Regional Office may help the Employees' Insurance Court on the latters' request to determine their claims by intimating them about the facts and the law.[19] The Regional Office would also calculate and communicate the rate of benefit to the Local Office and to the respective claimants.[20] In the case of minors, the information would be communicated to the father, or in his absence, to the mother and, in her absence, to any other person appointed by the competent authority.[21] Properly certified six-monthly declarations are

12. *Ibid.*, paras, 36-37.
13. E.S.I.C. instructions on Dependants' Benefit Procedure (referred to hereafter as I.D.B.P.), para. 1.
14. *Ibid.*, para. 10.
15. *Ibid.*, para. 11.
16. *Ibid.*
17. *Ibid.*, paras. 12-20.
18. *Ibid.*, para. 22.
19. *Ibid.*, para. 33.
20. *Ibid.*, para. 30.
21. *Ibid.*, para. 32.

due to be submitted along with the claims for the months of June and December.[22] Dependents' benefits are liable for review after considering objections presented by any one, on account of the death of a dependent or birth of new dependent such as a posthumons child or remarriage of a widow or marriage of a daughter, or attaining the age of fifteen years.[23] Where the rate of benefits is fixed by the E.I. Court, it alone is competent to revise the rate.[24] If a benefit is payable to a deceased dependent, it may be paid to the heirs or legal representatives provided the amount of benefit does not exceed Rs. 100; if it exceeds the above figure, the heirs, etc., would be required to produce a succession certificate from a court of law.[25]

Decentralized System of Maintaining Contribution Cards in the Local Office

The determination of entitlement to benefit is a crucial matter in social insurance administration. The title to benefits is determined on the basis of the contribution cards of the insured person. While the benefit is paid at the Local Office, the Regional Office, under a practice now being replaced, keeps the contribution cards to determine the rate of the benefit and to pass on the information to the Local Office through the system of shuttle cards, so called because they move to and from the regional and local offices. All the particulars necessary for the determination of the claim and the rate of benefit are posted on the shuttle card, the receipt of which from the Regional Office is a vital prerequisite for payment of benefit at the Local Office. A subcommittee appointed by the E.S.I. Corporation in 1955 to report on the working of the E.S.I. Scheme at Bombay, Kanpur, Delhi and Amritsar found that the procedure of local offices ascertaining the rates from the regional offices through the system of shuttle cards "involves some delay, particularly in case of outlying areas."[26] It was urged

22. *Ibid.*, para. 33.
23. *Ibid.*, para. 39-C.
24. *Ibid.*, paras. 52-58.
25. *Ibid.*, para. 52-A.
26. Report, p. 36.

before the Committee that the delay could be cut short either by maintaining the contribution cards in the local offices or at least in some central place in each centre.[27]

While conceding the attractiveness of the suggestion, the Committee in their Report referred to some possible abuses arising out of the change. They said:[28] "If another office is opened, the cost of maintaining such an office may increase the administrative cost. Besides, cash benefits become payable not on submission of first certificates but on presentation of first intermediate certificate, which gives about seven days for obtaining the rate from the Regional Office. We recommend, however, that this suggestion may be examined carefully from all aspects." In their Annual Report for the year 1956-57, the E.S.I. Corporation referred to the implementation of the above suggestion in Ujjain and Gwalior as an experimental measure.[29] Under this experimental system, the contribution cards are initially received from the employer by the Regional Office and thereafter, they are sent to the Local Office where these cards are maintained. The effect of this procedure is to prevent delays arising out of the transport or communication of shuttle cards. Under the new system as soon as a claim is received in the Local Office, title to benefit can be determined in the Local Office itself with reference to the contribution card.

The Annual Report for the subsequent year, *i.e.*, '57-'58, expressed satisfaction with the results of the experiment and extended the new procedure to a few more centres in Nagpur and Bombay areas. The beneficial results of the experiments enabled the Corporation to apply the system in the local offices in almost all the areas covered by the E.S.I. Scheme.[30]

Under the new system the contribution cards are maintained and the rates are calculated in the Local Office itself

27. *Ibid.*
28. *Ibid.*
29. E.S.I.C. Annual Report, 1956-57, pp. 28, 29.
30. E.S.I.C. Instructions on Sickness & Extended Sickness Benefit Procedure, March, 1960, pp. 23-27.

in cases:

(*a*) where the Local Office is situated outside the Regional Headquarters; or

(*b*) where there is only one Local Office at a place where the Regional Office is situated. The Local Office submits to the Regional Office daily the schedule of benefits paid by it.

But where the Local Office is situated in the same town as the Regional Headquarters and where there are more than one Local Office, the Contribution cards continue to remain at the Regional Office and the procedures prevailing before the decentralized system continue to remain in force. This is the case in Calcutta and Bombay, but in Delhi where there are three local offices the decentralized system is in operation.

The new system has led to the creation of what may be described as a sub-regional office in towns outside Regional Headquarters provided the town has two or more local offices, for example, in Coimbatore. The Regional Office designates one of the local offices as a Central Local Office. When the employers send the contribution cards to the Regional Office, the latter, after fulfilling the necessary steps with those cards, sends them to the Central Local Office. This Office will calculate the rates of those persons registered with itself and also of those registered with the other local offices in the town. The instructions make it clear that:[31] "In regard to the rates for other local offices, the Central Local Office will perform exactly the same functions as the Regional Office is doing now." The Local Office will send the shuttle card to the Central Local Office which will enter it in the diary, calculate the rate, fill up the shuttle card and despatch it to the Local Office which deals with the claimant. At the end of the benefit period the Central Local Office returns the cards to the Regional Office for custody and reference.

This decentralised system of keeping the Contribution Cards at the local office has proved to be a vital step towards

31. *Ibid.*, p. 27.

minimisation of delays[32] in payment of benefits. The system has anticipated the recommendation of a study by the I.L.O.:[33]

> "In view of the necessity to settle the claims for benefit without undue delay, especially those such as sickness and unemployment benefits for which claims cannot be made until the contingency insured against has actually arisen, it is desirable that the benefit papers should remain in the Local Office, at any rate so long as benefit continues to be payable, and that the contribution records of the insured persons should be readily available for reference, if required; in order to confirm title to benefit."

HEARINGS ON BENEFIT CLAIMS

The Employees' Insurance Courts

To provide hearings on benefit claims as a right under social security administration, as well as to furnish a means of adjudication with regard to the coverage of particular employers and employees by the Employees' State Insurance Act, the Act provides[34] for the establishment by the State governments of Employees' Insurance Courts in local areas, to be composed of such numbers of judges as the State Governments shall think fit. Persons who have been judicial officers or have been legal practitioners of at least five years' standing or eligible to be judges of these Courts.

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32. Several steps have been taken by the Corporation from time to time to tackle the problem of delay. Besides the regulations under the Act pamphlets have been prepared containing detailed instructions about the procedure at every stage. In 1959 the Corporation appointed a Sub-Committee to report on the matter and also entrusted the task of ascertaining the extent of the problem of delay to Messrs. N.C. Corporation (P) Ltd., (Sec. E.S.I.C. Report of the General Purposes Sub-committee on the working of the E.S.I.C. Scheme at Calcutta, Howrah, Assam, Madras, Madurai and Bangalore p. 8; Report on a Preliminary Survey of Delays in payment of Cash Benefit by N.C. Corporation (P) Ltd., Bombay (1960). In view of the more recent decentralised system of keeping the Contribution cards at the Local Office, discussed above, the problem of delay is not of much significance.

33. *Hand book of Social Insurance Administration* (1959) I.L.O. Geneva Part V, Note 2, p. 6.

34. S. 74.

As a Technical Co-operation Mission of the International Labour Office, which rendered a report on the organisation of the Employees' State Insurance scheme early in its operation,[35] pointed out in its report[36] the independence of the several Employees' State Insurance Courts gives rise to inevitable problems of co-ordination of their work, such as is required by the national character of the insurance scheme. The continuance of these problems is indicated by some diversity in the determinations of the particular Courts whose decisions have been examined in the course of the present study. The very composition of the Courts displays great variations. The States had designated for the various local areas prior to the end of the financial year 1958-59, as members of the Courts, district judges in 18 instances, subordinate judges in 5 instances, magistrates in 7 instances, industrial tribunal and labour court judges in 10 instances, and sub-divisional officers and deputy collectors in 6 instances.[37] Most of these judges were judicial officers prior to their designation while others were not; and the rank of those who were obviously varied considerably. When the existing variation among the States in methods of selecting judicial officers[38] is considered along with these factors, the probable diversity of qualifications among the judges of the Employees' Insurance Courts becomes apparent.

Substantial uniformity in the procedural rules of the Employees' Insurance Courts has been obtained through the adoption by the various States of rules suggested by the Central Government in consultation with the Corporation. Aside from the conditions of service of the judges and related matters, which are under the control of the State Governments, the administrative supervision of the Employees'

35. Report to the Government of India on the Organization of the Employees' State Insurance Scheme (1953).

36. Part I, para. 64.

37. Employees' State Insurance Corporation, Annual Report for the year 1958-59, App. XIX. The judges of 19 additional courts established in 1959-60 were drawn from similar sources. See the Corporation's Annual Report for that year, pp. 16-17. These lists appear not to be complete, since the Bombay City and Poona areas are not mentioned.

38. Law Commission of India, Fourteenth Report (1958), pp. 161-181.

Insurance Courts is entrusted, as it should be within a State, to the High Courts.[39] The procedure prescribed by the rules is simple and seems well adapted to the kinds of matters to be adjudicated. Proceedings are instituted by application; summons may be by registered post; the Court may call for a written statement from the opposite party; the Court is directed to formulate the issues at the initial hearing after examining the parties and the written material on file; and the Court may at any stage of a proceeding recall any witness and put to him such questions as the Court thinks fit.[40] Findings on the issues initially stated are required.[41] Costs are in the discretion of the Court, and poor persons earning less than particular amounts of wages specified by the State Government may be permitted to institute proceedings without payment of costs or fees.[42] A one-year limitation which the regulations specify for the commencement of a proceeding may be waived by the Court for sufficient reason.[43] The nature of the proceedings is such that, generally speaking, benefit claimants are not represented by counsel, but more frequently by officers of trade unions or by social workers.[44]

Pursuant to the policy of making Employees' Insurance Courts locally available without requiring the Courts themselves to travel, the Corporation and the States have established the Courts in such number as ordinarily to reduce the business of each considerably below the requirements of full-time operation. The rules themselves provide that "The State Government may constitute the presiding officer of any civil or criminal court in the State as a Court for the purpose of the Act and such Presiding Officer shall thereupon discharge the functions of the Court in addition to his own duties."[45] The same policy of selecting someone with other duties as the judge of the Employees' Insurance

39. U.P. Employees' Insurance Courts rules, 1952, Rules, 4-11.
40. *Id.*, rules 13, 20, 22, 24, 32.
41. *Id.*, rule 36.
42. *Id.*, rules 39, 46.
43. *Id.*, rule 17. See, however, note 87, *infra.*
44. V.A. Mutatkar, 'Adjudication of Disputes, Appeal Systems and Procedures' (Address before the Asian Regional Training Course organized by the I.L.O., New Delhi, 18 Nov. 1960) (mimeographed), pp. 4-5; I.L.O. *Report on the Course* (1961), p. 274.
45. Rule 4, cited *supra*, note 39.

Court has obviously been carried beyond the presiding officers of the civil and criminal courts, with the result that each Insurance Court is a part-time Tribunal whose judge could regard his functions in this capacity as less "his own" than his other duties. It is not possible to say on the basis of the present study whether the work of the Employees' Insurance Courts has suffered because of this factor.

Subject Matter of Proceedings Before the Employees' Insurance Courts: Partial Substitution of Appeal Tribunals

The Employees' State Insurance Act provides[46] that the Employees' Insurance Courts shall to the exclusion of the civil courts decide questions, among others, relating to the coverage and liability of employers and employees to pay contributions, and relating to claims for benefits. Their jurisdiction is invoked by application of either the Employees' State Insurance Corporation, an employer or employee raising a question of coverage or liability to pay contributions, or a claimant of benefits. With respect to benefit claims the questions most frequently involved in the decisions reviewed in the course of the present study were the existence, duration and percentage of temporary or permanent partial disability caused by employment injuries. These questions have by regulations of the Corporation been made determinable initially by medical boards constituted by the State Governments,[47] and on "appeal" by appeal tribunals consisting of the Employees' Insurance Courts which are enlarged to include assessors selected by these Courts.[48] The assessors in each instance consist of one or more medical experts and one or more officials or members from a trade union or unions. The appeal tribunals replace the Employees' Insurance Courts with respect to the matters assigned to them.

Of the 109 decisions of Employees' Insurance Courts and appeal tribunals in the regions of Bombay, Delhi, Kanpur and Madras, which have been examined in the course

46. Sec. 75.
47. Employees' State Insurance (General) Regulations (1950), ss. 72, 73, 75.
48. *Id.*, s. 76.

of this study, 35 were Insurance Court decisions and 74 were decisions of Appeal Tribunals. All of the latter involved questions of the percentage of disablement in permanent partial disability cases. Of the former, 15 concerned coverage and liability to pay contributions, 6 concerned entitlement to dependants' benefits, one involved the acceptability of alternative evidence to support a claim to medical benefits, 2 concerned questions of limitations on proceedings,[49] 2 involved the appealability of Appeal Tribunal decisions to the Court, and 9 involved claims by the Corporation against employers for indemnity and damages. Although the decisions examined constituted all of those rendered in the four regions in 1960, there were none by Appeal Tribunals and only 4, involving coverage and liability to contributions, in the Courts in the Madras region. In the other three regions there were 12 Court decisions in addition to the 74 by Appeal Tribunals.

The question has arisen whether the Employees' Insurance Courts, as statutory bodies, should entertain appeals from the Appeal Tribunals established by regulation; but the Insurance Courts, where the question has been presented in the decisions examined, have declined to do so.[50] It would, indeed, present a strange anomaly if one member of a Tribunal were afterwards to sit in review of a decision of the entire body; but the emergence of the issue, which was quite a natural one to raise, emphasizes the doubtful validity of the action of the Corporation in undertaking to substitute the Tribunals for the Courts in certain proceedings. So long as this substitution continues, the legal effectiveness of the Tribunals' decisions must rest, it would seem, on the participation in these decisions of the statutory judges.

Whether a practical justification existed for replacing the Employees' Insurance Courts with the Appeal Tribunals

49. One involved a dependant's claim and the other a claim by the Corporation for contributions.

50. Bombay Appeal Trib. Case No. 57/59 14 May '60 on reconsideration by the E.I.C.; *id.*, Case No. 68/59 (4 June '60) reconsidered. 2 Nov. '60; *id.*, Case No. 62/59 (4 June '60) on reconsideration by the E.I.C.

in disablement cases depends on further considerations. The Technical Co-operation Mission of the International Labour Office, previously mentioned, referred to the inappropriateness of a purely legal tribunal to decide questions "which have often an industrial rather than a legal significance", and recommended that the Corporation consider at a convenient opportunity the establishment of tripartite tribunals, consisting of employers' and employees' representatives and a legal chairman, in place of the existing Courts.[51] Delays and technicalities in the Courts' processes were also cited in support of this recommendation.[52] The establishment of the Appeal Tribunals preceded the recommendation, but may have been motivated by similar considerations. The nature of the delays and technicalities alluded to was not recited in the report, but may have consisted of the written statements and the oral testimony which are involved in even the simplified procedure of the Employees' State Insurance Courts. The appropriateness of such processes will be discussed below; but in relation to the stated industrial rather than legal significance of the issues in disablement cases, it is pertinent to remark that legal issues presented to courts in all kinds of proceedings, apart from those relating to procedure, are always practical questions which happen to be presented for judicial determination. They are so presented not because they are "legal" in some special sense but because the Courts are deemed capable, for practical reasons, of resolving according to law the socio-economic issues involved in them. The questions arising in social security cases are in this sense as legal as any others. Like others, they should be decided by the type of tribunal best adapted to handling them.

There is much to be said for the view that the existence, nature and extent of a personal injury or disease can better be determined in the first instance by a medical examination and, if necessary, verified by a re-examination, than by the trial proceedings which prevail in workmen's compensation administration in the United States, which have given rise

51. Report, *supra*, note 35, para. 63.
52. *Ibid.*

to considerable delay and expense.[53] Therefore the use of the Medical Boards and Appeal Tribunals has real justification, and hearings by the latter are scarcely necessary with respect to the purely medical determinations. The determination of percentage of disability not fixed by the statutory schedule,[54] however, involves not only the disability of the individual concerned, but also the effect upon his earning capacity, which the percentage is supposed to indicate. It can be argued that the estimation of loss of earning capacity is aided by expertness in relation to industrial operations and employment opportunities, such as a suitably chosen member of an Appeal Tribunal might supply. That a trade union member or official will supply this expertness seems highly doubtful, however; and if union member is to be included upon an Appeal Tribunal, the bias which his affiliation is likely to introduce should be offset by the addition of an assessor drawn from management. Whether such assessors are used or not, certain possible evidence bearing on the issue of disability, such as actual loss of earnings by the claimant, his experience in seeking work, and the view of personnel officers concerning his employability, could best be introduced and tested by the hearing process; generally, however, the percentage of disablement is determined by a rough estimate in comparison to the statutory percentages for specified injuries, without reference to actual experience in particular cases; and the continued use of hearings for this purpose may not be justified.

Decisions of the Appeal Tribunals

The decisions of the Appeal Tribunal in the Bombay

53. See A.F. Conard, 'Workmen's Compensation: Is It More Efficient than Employers' Liability?' 38 *Amer. Bar Ass'n. Four.* 1011 (1952).

54. The Indian Workmen's Compensation Act of 1923, like similar legislation in other countries, provides a statutory schedule which specifies the percentage of disability which shall be deemed to result from certain stated injuries, such as loss of sight or hearing or loss of extremities. (s. 4(b), (c) referring to Schedule I.) The liability of the Employees' State Insurance Corporation, which is substituted for that of employers under the Workmen's Compensation Act in factories to which the Insurance Act applies, is measured in disablement cases by reference to the Workmen's Compensation Act. See the Employees' State Insurance Act, ss. 52, 53, and schedule II. The Workmen's Compensation Act provides specifically in sec. 4(c) that in the case of an injury not listed in the schedule, causing permanent partial disablement, the percentage of disability shall reflect

region present the amazing record of an increase in each instance of the percentage of permanent partial disability previously found by the Medical Board.[55] Such a result suggests the conclusion that either the determinations of the Medical Board are so seriously deficient as to require remedial measures to be taken, or the appeal tribunal has become a haven for claimants possessing sufficient initiative and resources to carry their cases there. The only evidence available to the writers of the extent to which each branch of this conclusion is supportable is the judgments, or opinions, of the tribunal, written in each instance by the judge of the Employees' Insurance Court who presided. While some of these are confined to the announcement of conclusions different from those of the medical board and are consequently uninformative, a considerable number of judgments (opinions) recite facts underlying the conclussions, and are convincing to the effect that the medical board was in error and that the Appeal Tribunal supplied a needed corrective. Thus, in several cases evidence of actual loss of earnings by claimants was recited and relied upon as a measure of the degree of disablement.[56] In one case an increase in the award from 5 per cent to 30 per cent was tellingly justified by the statement that the grip of the right hand had been completely lost.[57] In another an increase from 3 per cent to 6 per cent in the case of a carpenter was justified by reference to the fact that he could no longer reach above his head with a tool.[58] There are other instances of effective recitals of the consequences of the injuries found to have been sustained.[59] In one case the Medical Board's statement of the facts is characterized as inaccurate,[60] and in another an original Medical Board

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the loss of earning capacity permanently caused by the injury.

55. In one case, however, No. 6/60 (17 Sep. '60), the Tribunal made the enhanced percentage award temporary instead of permanent as determined by the Medical Board, because of the likelihood that improvement in the claimant's condition might occur.

56. Cases No. 47/59 (22 Feb. '60), 1/60 (30 July '60), 46/59 (14 May '60), 5/60 (1960).

57. Case No. 3/60 (30 July '60).

58. Case No. 70/59 (29 July '60).

59. Cases No. 17/60 (1960), 15/60 (1960), 35/59 (6 Feb. '60), 38/59 (29 Feb., '60).

60. Case No. 50/60 (31 March '60).

award is preferred over a reduced award rendered afterward upon reconsideration, because the latter was unexplained.[61] In one instance the claimant's condition had changed for the worse after the Medical Board had made its decision.[62] In two instances the claimants were awarded more than they had asked, with opinions amply justifying the increases.[63] In three cases, to the accompaniment of opinions devoted to characterizing the claimants' demands as exaggerated, the awards inexplicably raised the Medical Boards' awards.[64] The opinions in two cases do not explain apparent inconsistencies among the awards made for the loss of a right hand or of portions of the hand which destroyed its use.[65] In one instance the Appeal Tribunal condemned the hospital treatment of the claimant's fractured arm, which was said to have been responsible for rendering a temporary disablement permanent, and called (by what authority does not appear) for the submission of the hospital records for future examination by the Tribunal.[66]

The opinions of the Delhi Appeal Tribunal explain the decisions less adequately, on the whole, than those in Bombay, and are far from presenting the same uniformity in enhancing the claimants' benefits which the latter display. Among the 15 Delhi cases examined, one terminates the Medical Board's award because of disappearance of the claimant's disability, 2 affirm the denial of any award, 4 continue the medical board's provisional award for an additional period, 4 render a provisional award permanent, and 4 increase the award of the medical board. In each instance the percentage of disability is stated to have been originally the conclusion of the Medical Assessor, in which the other two members of the Tribunal concurred.

Five of the six Kanpur Appeal Tribunal decisions

61. Case No. 18/60 (4 June '60).
62. Case No. 60/59 (1960).
63. Cases No. 5/60 (1960), 11/60 (1960).
64. Cases No. 29/59 (6;-60), 12/60 (1960), 14/60 (31 Oct. '60).
65. Cases No. 53/59 (14 May '60) (70% awarded because right hand rendered functionally useless), 11/59 (12 Jan. '60) (60% awarded because of total loss of use of hand). Compare the case cited in note 57, above.
66. Case No. 16/59 (12 Jan. '60).

that were examined increased the Medical Board award and one, involving an appeal by the Corporation, affirmed the Board's award. In one of the cases of increase a finding of 40 per cent disability was based on the entire loss of the use of the right hand, in contrast to the larger percentages in similar cases in Bombay.[67] In this case the Medical Assessor agreed with the 25 per cent award of the medical board but was overruled by his colleagues on the Appeal Tribunal, whereas in the other five cases the two colleagues agreed with his initial finding. The opinions seem adequate on the whole.

Except for the one case in Kanpur, the Appeal Tribunals have maintained unanimity. Difficulty in reconciling differences among the members hardly accounts, therefore, for the length of time some of the cases have remained pending after the appeals were taken. Only in Nagpur is the period definitely recorded, and there it ranged from 8 to 18 months in five cases and reached 4 years and 3 months in another in which the Chairman of the Tribunal, confronted by conflicting reports of the Medical Board on the basis of three different examinations of the claimant, ordered three years after the appeal had been taken that there be a re-examination. This examination was followed after another year by a fifth one which resulted in a report of no disability. The Appeal Tribunal found, nevertheless, that there was a limp in the claimant's gait and a slight wasting of muscles in the left thigh and leg, which produced a 20 per cent disablement.[68] In Bombay the length of time the appeals were pending can be ascertained approximately by referring to the case numbers, assigned *seriatim* in each year and comparing them with the dates of decision which are usually, but not always, given. There the shortest period appears to have been 3 months, with several decisions in 5 months, others after 12 and 14 months, and 7-9 months

67. Case of Shri Pyarey Lal (21 Sep. '60). The award here is consistent with the original schedule I of the Workmen's Compensation Act of 1923 which was applicable to the case. The Bombay award of 60% (*supra*, note 65) conformed to the schedule as subsequently amended, effective 1 June, 1959 but the case number indicates that the original schedule still applied.

68. Case of Shri Udai Raj (15 June '60).

apparently the median range. In Delhi the case numbers are not similarly indicative of the time of filing and are frequently not given.

Decisions of the Employees' Insurance Courts

The most numerous class of cases in the Employees' Insurance Courts is those involving coverage and liability to pay contributions. An additional group of cases involves the recovery by the Corporation of indemnity or damages from employers who have violated the law or persons who owe indemnity.[69] In 1959-60 the Employees' State Insurance Corporation brought 603 proceedings of these varieties. In addition to the cases brought in the Employees' Insurance Courts, the Corporation brought 1935 other proceedings to collect from employers a special contribution,[70] payable during periods before the regular contribution and benefit provisions of the Act are extended to their areas,[70a] and before the Courts are established in these areas.[71] Pending their establishment, enforcement of the special contribution may take place before special authorities (courts or tribunals) specified by the Central Government.[72] The large number of special contribution cases now before the Courts probably far exceeds the number of regular

69. Damages or indemnity or reimbursement are collectable under the Employees' Insurance Act from an employer who has violated a safety rule applicable to an establishment in which an industrial injury has led to the payment of benefits (s. 66), from a person, other than an employer who has paid contributions on behalf of an employee, if he is liable to compensate the employee for an industrial injury that has led to benefits (s. 67), from an employer or other person whose maintenance of insanitary conditions in a factory or tenement has caused excessive sickness benefits to be paid (s. 68); and from a person who has received benefits to which he was not entitled (s. 70).

70. Employees' State Insurance Corporation, Annual Report for 1959-60, p. 51.

70a. Employees' State Insurance Act, s. 73A.

71. Chapter VA of the Act, containing s. 73A, was extended to the whole of India except Jammu & Kashmir on November 24, 1951. Later complete extensions of Chapters IV, V and VI which provide respectively for benefits, contributions, and the permanent courts, have been made successively to different areas, and have been followed by the States' designation of Employees' Insurance Courts in these areas. See the annexure to the Act as officially published in pamphlet form as of 1 Feb. 1959, which lists the extensions, and Report, *supra* note 70, Appendix I.

72. Act, *supra*, note 70a, s. 73b. Designation of the special authorities has been by successive notifications of the Central Government.

contribution cases likely to be brought in the Employees' Insurance Courts in the same areas in future years after the entire scheme of the Act has become nation-wide and is thoroughly established and accepted. In the reported decisions examined for this study, the judgments (opinions) in the coverage cases are carefully drawn and appear to dispose satisfactorily of the issues. They will not be further discussed here, since they do not relate to benefit claims.

Among benefit cases in the Employees' Insurance Courts the most significant ones appear to be those relating to dependents' benefits. Some of these involve review of actions of the Corporation upon claims, while others constitute the initial action upon such claims, since the Act requires that the benefits to dependents other than widows and minor children shall be "at such rates (percentages of former wages) as may be determined by the Employees' Insurance Court having jurisdiction."[73] Very possibly most cases of this kind lead to decisions without contest or judicial judgment; but two judgments in Madras, in which contests were not pressed after having been originally indicated, have been examined.[74] In both of them the judgment identified the dependant entitled to benefits and determined that the maximum allowable under the statute[75] should be paid.

As is inevitable under legislation allowing dependants' benefits on account of deaths arising out of employment,[76] the question of casual connection between the employment and death is sometimes a difficult one, especially in heart cases. In such cases it is often not susceptible of medical determination. The employee dies on the job or immediately after leaving it, because of a condition which could have produced death at any time and under many circumstances,

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73. Sec. 53 (iii).

74. Cases of Ram Prasad (10 May '60) and Smt. Bahali (24 June '60).

75. Sec. 53 (iv) provides that for dependents other than widows and minor children one-half of the amounts payable for total permanent disablement shall be the maximum.

76. It is a common feature of workmen's compensation legislation that an injury, to be compensable, must arise out of as well as in the course of the employment. For the experience with this problem in the United States of America see Arthur Larson, *The Law of Workmen's Compensation* (1952), vol. 1, ss. 38.00-39.70.

but most probably as a result of some precipitating exertion; and the precise chain of events within the body of the deceased is not ascertainable by post-mortem examination. A commonsense determination, taking account of time sequences between work activity and the heart attack or death, the nature of the activity on the job, and any external symptoms, such as expressions caused by pain, which the deceased may have manifested, is therefore the best that can be achieved. The Employees' State Insurance Corporation, which has published an excellent booklet of Instructions on Temporary Disablement Benefit Law,[77] directs that all fatal and non-fatal cases of heart failure be referred to headquarters for a determination of whether the case is one of employment injury or not. If the administrative conclusion is negative, a medical expert is invariably to be produced in court upon susbsequent challenge to the decision, to testify in support of the conclusion.[78]

Three cases of fatal heart failure, which arose in the Bombay Employees' Insurance Court in 1960, appear from the opinions to have been well decided. In one, in which the claim was rejected, the judge disbelieved improbable testimony, offered by the claimant, to the effect that the deceased had undergone unusually heavy exertion on the job just before the fatal seizure.[79] In another, in which the deceased had done more than a half-day of strenuous painting overhead just before his attack, the claim was allowed even though in this case, as in the previous one, the medical evidence was that the deceased's condition might have produced his death at any time without external cause.[80] In the third case, the attack occurred shortly after starting-time in the morning, without evidence of prior exertion on the employee's part; hence the claim was rejected.[81]

Another recurring question in dependants' cases, suitable for judicial determination on the basis of oral testimony, is that of dependancy of the claimant on the deceased

77. Issued in March, 1960.
78. *Op. cit.*, p. 42.
79. Application No. E.S.I. 158/58 (1 Nov. '60).
80. Application No. E.I.C. 146 of 1956 (11 June '60).
81. Application No. 94 of 1958 (11 June '60).

prior to the death, which is necessary to an award in favour of persons other than a widow or minor children.[82] Sometimes rival claims to dependancy are presented. Three cases in Kanpur, among those examined in the course of this study, presented such dependancy questions, and appear to have been well decided.

In one case the Bombay Court had to consider whether an employee might recover medical expenses from the Corporation and the State, where he had incurred them under emergency conditions when no panel doctor was available. The Act provides for the Corporation and the State Governments to furnish free medical services under arrangements to be agreed upon between them,[83] and further provides that an insured person shall not be entitled to claim reimbursement from the Corporation of expenditures for such services, "except as may be provided by the regulations".[84] Since no such regulation had been issued, the Court concluded that the Corporation could not be held responsible for the charges. The Court further decided that it could entertain the claim against the State by virtue of the provision in the Act that it might decide "any claim for the recovery of any benefit admissible under this Act",[85] but that in the absence of a regulation permitting recovery from the State, such as the Court thought might well be enacted, no basis in substantive law existed for decreeing reimbursement. It was held by the same Court in another case, however, that the rule-making power of the State Governments, conferred by the Act,[86] extended only to matters of procedure and not to such substantive matters as the period of limitation applicable to claims by the Corporation in the Employees' Insurance Courts for employers' contributions.[87] Prior decisions in Madras and Poona were based on the same view. A decision of the Delhi Court, by contrast, applies the

82. Employees' State Insurance Act, s. 53 (iii).
83. S. 57 (2).
84. S. 75 (2) (f).
85. Application No. 28 of 1960 (15 Dec. '60).
86. S. 96 (1).
87. Application No. 69 of 1957 (18 Feb. '60). The Limitation Act was held applicable, rather than s. 17 of the Employees' Insurance Court Rules as enacted in Bombay.

limitation prescribed in the State regulation in a similar case, without questioning its validity.[88]

Administrative Aspects of Adjudication in the Tribunals and Courts

In one case the Delhi Court, adhering to a policy similar to that of the Employees' State Insurance Corporation in relaxing its regulations when circumstances render it appropriate,[89] exercised its statutory power to waive the prescribed one-year period within which claims may be made,[90] where the claimant was an illiterate young girl claiming dependants' benefit on account of the death of her husband.[91] The Corporation, the Appeal Tribunals, and the Employees' Insurance Courts seem generally to adopt a sympathetic rather than a litigious attitude toward claimants. The Bombay Tribunal in one case[92] relaxed the three-month limitation on appeals to the tribunals, which is prescribed in the regulations.[93] In one dependents' case the Corporation supplied the evidence on which the Court based its conclusion that a death arose out of the employment,[94] and in another case in the Bombay High Court it offered to produce a medical certificate which the claimant desired to have introduced, but which the Court thought superfluous because the required legal effect had already been given to it.[95] The Bombay Appeal Tribunal has made considerable use of the authority conferred on the Employees' Insurance Courts[96] to allocate costs between the parties. Out of 53 cases in 1960, the Tribunal awarded costs against the "opposite party" (Employees' State Insurance Corporation) in 16. In one-half of these cases the award was Rs. 10, in six it was Rs. 15, in one Rs. 20, and in one, in which the tribunal thought resistance to the

88. Suit No. 19 of 1960 (29 July '60).
89. Employees' State Insurance (General) Regulations, s. 100.
90. Employees' State Insurance Act, s. 80.
91. Suit No. 61 of 1959 (15 Jan. '60).
92. Case No. 19/59 (12 Jan. '60).
93. Regulations, *supra*, note 88, s. 74. The regulations make no provision for such relaxation.
94. Bombay Application No. E.I.C. 146 of 1956 (11 June '60).
95. First Appeal No. 24 of 1957 (18 Oct. '60).
96. *Supra*, note 42.

claim was completely unjustified, it was Rs. 50. The Kanpur Tribunal, by contrast, specifically left the costs as they had been incurred in all of the cases before it, including one in which the Corporation had appealed unsuccessfully.[97] The judgments of the Employees' Insurance Courts which were examined in the course of this study did not deal specifically with costs except in one instance in Kanpur, in which the costs were left as they had been incurred. The superficial impression created by these cases is that, not as a means of disciplining the Corporation but as a means of assumption by the insurance scheme of a legitimate cost of operation, somewhat greater use of the power to award costs to plaintiffs and appellants might be made in instances where the prosecution of the claim was not unreasonable.

With respect to the duration of the proceedings, the record of the Bombay Appeal Tribunal, summarized above, is much better than that of the Employees' Insurance Court in that area, perhaps because oral testimony, other than that of the claimant, is usually not required before the Appeal Tribunal. In only one of the claims cases in the Court of that area, which were examined in the course of this study, was the decision reached within a year. In the other three the time consumed was between 1 and 2 years in two and about 4 years in one. In the three cases examined in Kanpur the record was better, showing elapsed times of 2 months and 12 days, 7 months and 15 days, and just under one year. The chief reason for the delays in Bombay was doubtless pressure of work; but from the standpoint of achieving the purposes of the insurance scheme, improvement seems imperative. It would appear, at least superficially, that the record of performance of the Appeal Tribunals could also be considerably improved; for if there were no backlog of pending cases, it ought to be possible to dispose of the appeals in 45 days.[98]

97. Case of Shri Sheo Baran (11 May '60).

98. In the United Kingdom the maximum elapsed time in similar cases is said to be 6 to 7 weeks. *Committee on Administrative Tribunals and Enquiries, Minutes of Evidence* (1956), question 348, p. 40.

The Role of the High Courts

The available decisions of the High Courts on certification or appeal on significant questions of law in claims cases are too few to render an analysis of them fruitful. There are as yet no reported cases of this nature, and only one manuscript decision, in the High Court of Bombay[99] has come to hand. It involved a question of the discretion of the Employees' Insurance Corporation to accept or reject evidence of sickness, alternative to a certificate from an Insurance Medical Officer. It was held that the Corporation has complete discretion. The Court noted, however, that bad faith on the part of the Corporation was not alleged, and the decision hardly means that an abuse of discretion would not constitute an excess of statutory authority which could be corrected as an error of law.

The foregoing appeal was pending in the High Court for at least three years. The general problem of delay in the High Courts is well known, and considerable efforts are being made to overcome it. Since it is common to all varieties of litigation except those which are accorded priority by statute, a special point can hardly be made of it in relation to Employees' Insurance; but its effects on claimants of relatively small sums who are usually under economic stress, are particularly grave. Whether consideration should be given to legislation preferring such cases over others depends on broader questions of judicial administration and is beyond the competence of the present writers to decide. Despite the continuance of delays, High Court review would remain essential to the proper application of this, as of other, laws. One hopes that the advantage of having it can some day be purchased without the disadvantages which now accompany it.

CONCLUSIONS

This study indicates the extent of attention, the variety of experimentation, and the eagerness to simplify the procedures in the determination, of claims and fulfill statutory

99. First Appeal No. 24 of 1957, decided 18 Oct., 1960.

obligations without delays, which have characterized the administration of the benefit provisions of the Employees' State Insurance Act. The administrative procedures have evolved in such a way that the sub-committees appointed by the Corporation and we, in our interviews, have found that claims are generally met with little or no delay. A special study made in Bombay by the N.C. Corporation as consultants came to a similar conclusion. The decentralized system of maintaining contribution cards in the local offices has contributed much to the quick disposal of claims. There is ample evidence to show that delays do not constitute a serious problem under the prevailing procedures. Still, one may raise the question whether the procedures themselves are satisfactory.

The validity of a procedure must be tested by its simplicity consistent with the rationale of its purpose. Simplicity, however desirable, cannot be isolated from the purposefulness of procedures. It is the purpose of a procedure to satisfy the beneficiary while securing the observance of the governing statute. Any review of the procedures must be attempted from this double angle. The Officer on Special Duty and the Organisation and Methods division under him have paid a great deal of attention to these matters, and the pamphlets on law and procedures issued by them bear testimony to their earnest endeavours to simplify procedures consistent with the governing of purpose.

The procedure in respect of maternity benefit seems to be the most complicated both in respect of conditions of eligibility and number of certificates. Maternity is not difficult to establish and therefore procedures regarding the maternity benefit can be very much simplified. It may be suggested that the Local Office may require only three points of information: (1) that the claimant is an insured employee (2) that confinement has taken place or will occur and (3) that she has abstained from work for twelve weeks either before and during or during and after confinement. Certification of these items of information should enable a person to obtain maternity benefit provided her contribution record satisfies the eligibility test under sickness benefit rules.

Regulations 76-A and 83-A and the instructions as to the submission of a claim for permanent disablement, or dependents' benefits require a claim to be made for one or more calendar months. The Local Office however gives notice in the third week of the previous month and the claim is to be made in the first week of the next month. This seems to indicate that the claims are generally made every month. In view of the long-range nature of these benefits the payments may be made by the Local Office on the basis of the initial claim during such period as there is no change in the condition on which payment depends. Changes in condition or status which require modification in payment of benefit are required to be reported by the claimant under regulation 106. These can also be ascertained periodically by the Local Office. The six-monthly declarations under regulation 107 take care of these changes in condition or status. Abolition of the monthly claim requirements is therefore suggested.

Within the framework of a scheme which provides for hearings in Employees' Insurance benefit cases before Tribunals that are part of the regular state-administered judicial system of India, only limited improvement in the composition and methods of these Tribunals is probable. Under this system, differences and inadequacies in the selection of judges[1] and in some details of procedure, not covered by the standard rules, are bound to persist. There will, as well, be inadequate assurance that the judges and the state administrators of the trial courts will be sufficiently aware of the needs to be met by Employees' Insurance. The sharing of judicial time with other official duties is also likely to continue.

Whether or not other changes are made, consideration might well be given to abolishing the Appeal Tribunals, anomalously established by regulation, or supplanting them with statutory tribunals, each composed of a management as well as labour assessor in addition to a judge and medical assessor. In the alternative, strictly medical questions

1. *The Fourteenth Report of the Indian Law Commission* (1958), pp. 162-175.

now coming before these Tribunals, such as the existence and nature of disabilities, might well be made conclusively determinable by medical review boards, composed of physicians proceeding primarily by re-examinations instead of hearings, or by such boards with lay chairmen.[2] Either alternative should result in improvement.

If it were feasible to consider departing in principle from the present scheme of Courts, the provision of a national system of Administrative Tribunals in the Employees' State Insurance Corporation or the Ministry of Labour outside the Corporation, might be taken under advisement. Such a system need not be elaborate. It could be readily adjusted to changing needs if the social security scheme should be enlarged, and it should result in greater unity of administration and uniformity of decision than the existing system. Review in the High Courts should continue to be provided. To provide hearings in the various localities the tribunals could move from point to point within specified areas or could be suitably composed of persons serving part time. The principal drawback would be the absence of complete detachment of the tribunals from the administration which made the initial claims determinations. The cost of such a system would be paid from the Employees' Insurance Fund or from Central Government revenues; but if substantial advantages to the administration of benefits would result, fiscal considerations should hardly stand in the way of their attainment.

Both the British and the American social security systems provide for administrative tribunals of the kind here suggested. In the United Kingdom they consist of local Tribunals and Medical Appeal Tribunals.[3] Both have lawyers as chairmen. All members of the local Tribunals serve on a part-time basis. Only the chairman is compensated. They proceed by means of hearings, including

2. See S.T. Divers, *Appeal Systems and Procedures* (address before the Asian Regional Training Course organized by the I.L.O., New Delhi, 18 Nov., 1960) (mimeographed), pp. 1-2, I.L.O. *Report on the Course* (1961), p. 287.

3. See Sir Geoffrey S. King, *The Ministry of Pensions and National Insurance* (1958), pp. 92-93; *Committee on Administrative Tribunals and Enquiries, Minutes of Evidence* (1956), pp. 30-42.

oral arguments and trials when necessary. The Medical Appeal Tribunals, numbering less than 20 in the United Kingdom, follow informal examining procedures such as are suggested above for possible Indian tribunals of this nature. A further appeal lies from the local Tribunals (but only with leave if the Tribunal is unanimous) to the National Insurance Commissioner; and certain questions are reserved for the Minister of Pensions and National Insurance. Judicial review by the High Court in writ proceedings is possible. Minister's decisions may be appealed to a single judge of the High Court, or in Scotland to the Court of Sessions.[4]

In the United States, hearings, when requested, are accorded to claimants by Hearing Examiners appointed under the Federal Administrative Procedure Act,[5] who form a corps in the Office of Hearings and Appeals under the over-all Social Security Administration. The Office is separate from the Bureau of Old Age and Survivors Insurance, which is also in the Social Security Administration and handles claims in the first instance. An Appeals Council serves as an appellate body in the Office with respect to the decisions of Hearing Examiners. Judicial review may be had in the United States District Courts.[6]

Both the British and the American hearing systems have given general satisfaction. The latter, however, handled only Old Age and Survivors Insurance claims, involving mainly questions of family relationship and

4. King, *op. cit.*, pp. 87-90.

5. 60 Stat. 237 (1960), 5 U.S.C.A. ss. 1001-1011. For an account of the Hearing Examiner system see R.F. Fuchs, 'The Hearing Officer Problem—Symptom and Symbol,' 40 *Cornell L. Q.* 281 (1955).

6. A general account of the hearing system and of its original establishment is contained in the Monograph of the Attorney-General's Committee on Administrative Procedure on the Social Security Board (as it then was), Part 3 of Sen. Doc. No. 10, 77th Cong., 1st sess. (1941). Originally the Appeals Council, through its chairman, performed administrative functions with relation to the Hearing Examiners, then known as referees; but now both are within the Office, which is headed by an administrator who has independent powers and also serves as chairman of the Appeals Council. For a contemporary account see W.W. Mode, *The Appeals Process in Social Security* (address before the Asian Regional Training Course organized by the I.L.O., New Delhi, 18 Nov., 1960) (mimeographed); I.L.O. *Report on the Course* (1961) pp. 277-282.

dependency, until amendments to the Social Security Act, which became effective in 1957,[7] provided benefits for total permanent disability. Since that time the case load and number of Hearing Examiners have sharply increased, and the District Courts have reversed a far larger percentage of claims denials coming before them than before. These reversals are rectifying a narrow view of what constitutes total permanent disability, which has resulted from a cautious policy in the Office of Hearings and Appeals, rather than from any bias of the Hearing Examiners and Appeals Council in favour of the decisions of the Bureau. Judicial review operates to correct such errors. Although there have been some rumblings of dissatisfaction with certain methods of supervision employed by the Office of Hearings and Appeals, including undue criticism by it of past decisions of the Hearing Examiners, objections to the system stem mainly from a conception of the hearing process in such cases as adversary,[8] calling for a strictly independent tribunal. The philosophy of social security administration is, however, not one of withholding benefits whenever possible, but of paying them in all proper cases.[9] Hence the hearings are in fact exploratory rather than adversary, with the Hearing Officer or Chairman seeking to assist the parties to develop the case so that it may be decided correctly.[10] Complete separation of the tribunals from the agency administering the statute may, therefore, not confer an advantage.

In India, in all probability, partly because administrative systems, like other institutions, have a way of growing

7. The Act as amended will be found at 42 U.S.C.A., ss. 401-425; the hearing system has been established by regulations which are printed at Code Fed. Reg. Pit. 20, ss. 403. 709-403, 711.

8. The criticisms and the response of the Office of Hearings and Appeals to them appear in *Hearings on Administration of the Social Security Disability Insurance Program*, before the Sub-committee on Administration of the Social Security Laws, House Committee on Ways and Means, 86th Cong., 1st session (1959).

9. *Cf. Minutes of evidence*, *supra* note 3, questions 247, 295, pp. 31, 36.

10. More often than not, counsel do not appear for either side in hearings under the American system. Mode, *op. cit.*, *supra*, note 6, p. 3. As to the absence of counsel and the role of the chairman in the English local Tribunals see *Minutes of Evidence supra*, note 3, App. II, pp. 147-149.

from their original foundations, the hearing tribunals in the Employees' State Insurance scheme will continue to be state courts. It seems essential, however, that the obvious weaknesses and unevenness in the operation of the present plan be reduced by continuous scrutiny and efforts to secure improvement from the centre through legislation or otherwise. This matter will no doubt receive attention in the course of the consideration the Employees' State Insurance Corporation gives to attaining the purposes of the legislation it administers. Even so simple a device as circulating to interested persons and agencies and to the Employees' Insurance Courts adequate information as to volume of proceedings and content of decisions in the various States might have beneficial effects. The Corporation already advises claimants in its printed forms communicating Medical Board decisions with regard to their rights to secure hearings before the appeal tribunals, and the same practice might be extended with relation to the Employees' Insurance Courts. In this way unintended lapses tend to be reduced and greater uniformity in the use by claimants of the remedies available to them may be brought about. The present unevenness of resort to these remedies may be caused by lack of knowledge of them, or an absence of disposition by labour unions to promote their use, in some regions and not in others. So accidental a factor needs to be overcome if possible.

The above suggestions are made with a view to bringing about further improvements in the work that is already being done efficiently by the Corporation and its Regional and Local Office personnel all over the country. This work needs constant attention, periodical review and perpetual vigilance so as to serve the major purposes of social security without impediments.